No: Discontinuity can improve patient care

At first blush, there are few values in health care that seem more self-evidently important than preserving continuity. Only a masochist could possibly take the "continuity doesn't matter" side of this debate!

But things are not so simple. Assume that you have found the perfect primary care physician—someone who cares about not just your health care but your health, not just your protoplasm but your values. She knows your family and understands what makes you tick. She is a terrific clinician. Is this the person you want operating on your cerebral aneurysm? Will you wait for her to arrive when you are hypotensive in the emergency department?

Of course not. We decided long ago that there were fundamental advantages to having a single primary care physician whose job was to oversee your care during childhood (pediatrician) or adult life (general internist or family physician). But we also recognized that having this person provide all your specialized health care needs made no more sense than having a single professor teach all your college courses. There are simply some practices whose cognitive or technical complexity and time sensitivity render a single provider not just impractical but downright dangerous.

Several recent trends have added to the importance of what I will call "advantageous and purposeful discontinuities." First, a burgeoning literature confirms that practice often does make perfect in caring for patients across a wide array of diseases and procedures.[1] Second, the increasing computerization of information flow means that we can more easily transfer patient data without significant "voltage drops." Finally, the growing scope and complexity of primary care practice—now encompassing disease management, health promotion, genetic counseling, and more—has left primary physicians with less time and inclination to care for patients across the continuum.

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Consultation with another physician may reveal new clinical findings that improve care

Perhaps the most prominent recent challenge to continuity in American medicine is the hospitalist movement, in which a separate physician assumes the role of providing general hospital care in place of primary care physicians.[2] Although some have critiqued the new model because of its inpatient-outpatient discontinuity, increasingly persuasive evidence demonstrates that the model improves the efficiency and possibly the quality of inpatient care.[3,4] Moreover, I would argue that within-hospital continuity *improves* when hospitalists are involved. By creating an advantageous and purposeful discontinuity at hospital admission and discharge, the hospitalist can do things between dawn and dusk that are logistically impossible for busy primary care physicians: see patients twice, meet with families, react to abnormal laboratory test results and changes in patient status, and meet with consultants. Effective hospitalist programs find ways to make certain that primary care physicians remain informed about and appropriately involved in the key events of the hospitalization and that as little information as possible is lost in the transitions.

Finally, discontinuities can provide an opportunity for a beneficial second look. Tandeter and Vinson recently described 2 cases in which a second physician's examination revealed findings that the primary care physician had overlooked.[5] "Continuity of care," they wrote, " . . . may keep us from seeing gradual changes in our patients and may leave us with the illusion of a lack of change. When the overlooked changes are those of an insidious new disease developing on top of previous pathologies, the failure to diagnose a significant problem can result."[5(p423)]

Let us continue to value continuity, but let us not be its slaves when an advantageous and purposeful discontinuity will improve the care of our patients.

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